Account Number_____

Columbia Urological Associates, P.A.

PATIENT HISTORY FORM/UPDATE

Name_____ Today's Date _____
Social Security # _____Date of Birth _____Age _____
Email Address: _____Sex: M or F
Referring Physician_____
Family Doctor/PCP_____
Reason For Today's Visit_____

1. What name do you use for health insurance? _____
2. Current Address:
   _____
   _____
3. Home telephone number: _____Cell phone:_____
4. Are you currently employed? ___ Yes ___ No
   Please indicate your employer name and address:
   _____
   _____Work phone:_____
5. Financially Responsible Party (if other than self):_____
6. Name and telephone number of emergency contact:_____
   _____
   _____
7. Please list all allergies._____
   _____
8. Please list all medications including dosage and instructions:
   _____
   _____
9. Have you had the pneumonia vaccine?____Yes_____No
   Pharmacy (Name and Number):_____

Surgical History: (Circle all that apply)

Cystoscopy	Appendix Removed	Hernia Repair	Bladder Surgery
Defibrillator	Hip Replacement	Kidney Stone Surgery	Gall Bladder
Hysterectomy	Lithotripsy	Heart Bypass	Joint Replacement
Prostate Biopsy	Heart Stent	Knee Replacement	Prostate Removal
Heart Valve	Lumbar Disc	Prostate Resection	Pacemaker
Vasectomy			

Other Surgeries:_____

Medical Problems: Circle all that Apply:

Bladder Cancer	Anxiety	Endometriosis	Diabetes Type I
UTIs	Atrial Fibrillation	GERD	Diabetes Type II
Elevated PSA	Congest. Heart Failure	Heart Attack	Mitral Valve Prolapse
Enlarged Prostate	Depression	High Blood Pressure	Emphysema
Kidney Cancer	Hepatitis	High Cholesterol	Blood in Urine
Kidney Stones	HIV	Stroke	
Prostate Cancer	Diverticulitis	Kidney Failure	

Cancer: _____
Other Medical Problems: _____

Family History: (Circle all that Apply)

Kidney Cancer Anesthesia Reactions Kidney Stones Bleeding Disorder
Prostate Cancer Sickle Cell Anemia
Other: _____

Social History: (Circle all that Apply)

Status: Single Married Widowed Divorced Other
Tobacco Use: Current Type:_____Packs per Day:_____
Former How many years ago did you quit?_____
Never
Alcohol Use: Current Daily Intake:_____
Former How many years ago did you quit?_____
Never
Caffeinated Drinks per Day: 0 1 2 3 4+

Language: _____
Race: White Black\African American Hispanic or Latino Asian Unknown
Ethnicity: Hispanic or Latino Not Hispanic or Latino

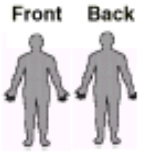
Review Of Systems:	**Circle All That Apply:**		
Constitutional:	Fever	Chills	Headache
Eyes:	Blurry Vision	Double Vision	Pain
Allergic/Immunologic:	Hay Fever	Drug Allergies	
Neurological:	Tremors	Dizziness	Numbness/Tingling
Endocrine:	Excessive Thirst	Too Hot/Cold	Tired/Sluggish
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Indigestion/Heartburn
Cardiovascular:	Chest Pain	Varicose Veins	High Blood Pressure
Integumentary/Skin:	Skin Rash	Boils	Persistent Itching
Musculoskeletal:	Joint Pain	Neck Pain	Back Pain
Ears/Nose/Throat/Mouth:	Ear Infection	Sore Throat	Sinus Problems
Genitourinary:	Urine Retention	Painful Urination	Urinary Frequency
	Urine Leakage	Urinary Hesitancy	Urgency of Urination
Respiratory:	Wheezing	Frequent Cough	Shortness of Breath
Hematologic/Lymphatic:	Swollen Glands	Blood Clotting Problems	
Psychologic:	Depression	Suicidal Thoughts	

History of Present Illness

Please answer the following questions

Location of the problem

Abdomen Back Leg
Other _____
_____
_____



On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago
Other _____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side
Other _____

How long does the problem last?

30 minutes 1 hour It is always there

Other _____

Is anything else occurring at the same time?

YES NO If yes, please explain.
Nausea Rash Headaches
Other _____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there
Other _____

Does the problem interfere with your normal functions?
Yes ☐ No ☐ If yes, please explain

Patient Signature: _____